

FILED AUG 30 1956

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29573

STATE FILE NUMBER

 Registration District No. 337 Primary Registration District No. 4497 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLARENCE</u>		c. CITY OR TOWN <u>CLARENCE 1020</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		Length of stay in lb <u>21 YRS</u>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>TAYLOR</u> Last <u>SPENCER</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 29 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>SALINE CO MO</u>
13. FATHER'S NAME <u>JOSEPH SPENCER</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA BLANCHARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>GRACE HARVEY CLARENCE MO</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiovascular Renal Hemiparesis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>August 6, 1956</u> to <u>Aug. 18, 1956</u> and last saw <u>him</u> alive on <u>Aug 18, 1956</u> . Death occurred at <u>11:20 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. Edrington D.O.</u>		22b. ADDRESS <u>Clarence MO.</u>	22c. DATE SIGNED <u>8-23-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-21-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Charles V. Young Clarence Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-24-56</u>	26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

AUG 30 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Charles V. Greaney*

Licensed Embalmer No. *46*

P. O. Address *Cleveland*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.